Reset

COVID-19 (Coronavirus) Disclosure/Consent

Patient Name: _____

Current studies indicate that some dental procedures create aerosolized particles (similar to a sneeze) of the virus that causes COVID-19, which can linger in the air for minutes to sometimes hours, which can result in transmission of COVID-19 (Coronavirus) from an infected person.

I understand and acknowledge this information and hereby declare that I have a dental condition that requires prompt care or I have a child with a dental condition that requires prompt care.
_____ (Initial)

I hereby affirm that my dentist/surgeon and anesthesiologist have discussed with me the preventative measures being taken to minimize the risk of COVID-19 (Coronavirus) transmission.
_____ (Initial)

I fully understand that proceeding with the treatment today increases my exposure/my child's exposure and therefore my risk of contracting community acquired COVID-19 (Coronavirus) infection.
Acquiring such infection can lead to symptoms such as fever, chest pain, shortness of breath and further respiratory complications. Severe disease can also lead to: prolonged hospitalization, intensive care admission, mechanical ventilation, and/or possible death.

I also affirm that neither I/my child, nor any of my immediate family members have been exposed to or had any of the following symptoms in the past 14 days:

1) Fever (≥100.4° F)
2) Shortness of breath
3) Dry cough
4) Fatigue and body aching
5) Chest pain
6) Confirmed or suspected COVID-19 (Coronavirus) infection

I am consenting to this procedure with full understanding and disclosure of such risks and alternatives, and all my questions were answered to my satisfaction.

Name (printed): _____

Signature: _____

Relationship to patient (if applicable): _____

Date: _____